**IN THE UNITED STATES DISTRICT COURT**

**FOR THE NORTHERN DISTRICT OF IOWA**

**WESTERN DIVISION**

JOHN W. DeBUHR,
Plaintiff,
vs.

JO ANNE B. BARNHART, Commissioner of Social Security,[(1)]

Defendant.

No. **C01-4018-MWB**

**REPORT AND**

**RECOMMENDATION**

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## *I. INTRODUCTION*

The plaintiff John W. DeBuhr ("DeBuhr") appeals the denial by the administrative law judge ("ALJ") of Title XVI supplemental security income ("SSI") and Title II disability insurance ("DI") benefits. DeBuhr

argues the ALJ erred in the following respects: (1) the ALJ improperly rejected the opinions of treating physicians, and (2) the ALJ failed to ask proper hypothetical questions of the Vocational Expert. (Doc. No. 9, pp. 16-25)

## *II. PROCEDURAL AND FACTUAL BACKGROUND*

### *A. Procedural Background*

DeBuhr filed applications for DI and SSI benefits on May 12, 1997, alleging a disability onset date of February 13, 1997. (R. 148-50, 631-34) The applications were denied initially (R. 121, 635), and upon reconsideration. (R. 122, 636) DeBuhr then requested a hearing, which was held on February 10, 1999, in Sioux City, Iowa, before ALJ Ronald D. Lahners. (R. at 46-120) Attorney Dennis Mahr represented DeBuhr at the hearing. DeBuhr, William Sievers, Bob Sievers, Christy Smith, and Vocational Expert ("VE") Sandra Trudeau all testified at the hearing.

On April 22, 1999, the ALJ ruled DeBuhr was not entitled to DI or SSI benefits. (R. 13-31) The Appeals Council of the Social Security Administration denied DeBuhr's request for review on January 23, 2001 (R. 5-6), making the ALJ's decision the final decision of the Commissioner.

DeBuhr filed a timely complaint on February 16, 2001, seeking judicial review of the ALJ's ruling. (Doc. No. 3) On September 20, 1999, by Administrative Order #1447, Chief Judge Mark W. Bennett referred this matter to the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(b)(1)(B), for the filing of a report and recommended disposition of DeBuhr's claim. DeBuhr filed a brief supporting his claim on June 25, 2001 (Doc. No. 9). On August 17, 2001, the Commissioner of Social Security filed a responsive brief (Doc. No. 10). DeBuhr filed a reply brief on August 24, 2001 (Doc. No. 11). The court now deems the matter fully submitted, and pursuant to 42 U.S.C. § 405(g), turns to a review of DeBuhr's claim for benefits.

### *B. Factual Background1. Introductory facts and DeBuhr's daily activities*

At the time of the ALJ hearing on February 10, 1999, DeBuhr was thirty-four years old and weighed 165 pounds. (R.101) He had received no income from any source since February 13, 1997 (*id*.), the alleged disability onset date. DeBuhr testified he had graduated from high school, and then had joined the Army, from which he had received an honorable discharge.[(2)] (R. 101-02)

DeBuhr described his disability as follows:

My most severe problem would be my, me being a manic bipolar manic depressant. Some reason I have a hard time being treated very unfairly, at least in my eyes and I tell the bosses like it is and I end up leaving a lot of my jobs because I don't think I'm treated or paid fairly. But my back can be rated right up there. I have problems with my back every day. Some days I can hardly walk. And I did that back in '85 and '86 making Steal Colverts (sic). I was carrying a bunch of heavy steal and all of a sudden my back went and ever since then, I've had back, major back problems to the point where I could hardly walk because the pain shoots all the way down my legs. I constantly have people crack my back or walk on it. I'm always constantly stretching or whatever. It's hard for me to sit still for too long. I stand, it's a

problem, it just, you never know. Some days it's alright.

(R. 104) At the time of the hearing, DeBuhr did not have a regular doctor - the last doctor he had seen had been on October 30, 1998, when he had gone to the Cherokee Mental Health Center for four days because of a manic episode. (R. 104-05) The only medication he was taking was Depakote.[(3)] (R. 105)

DeBuhr's work history consisted of jobs involving medium or heavy semi-skilled or unskilled labor. (R. 102-03, 187, 225) He reported his last job was as a laborer at an employment agency, where he worked from July 1996 to May 1997 (except for the period from February to April, 1997, when he was hospitalized). (R. 187) Before that, from August 1995 to May 1996, he had been a warehouseman and deliverer for an electrical supply company. (*Id*.) Prior to that, from November 1994 to August 1995, he had been an assembler. (*Id*.) Before that, from April 1992 to July 1992, he had been a garbage man. (*Id*.) Before holding these jobs, DeBuhr had worked as a janitor, assembler, and warehouseman. (*Id*.)

DeBuhr described a history of losing jobs because of conflicts with his superiors. (R. 108-09) He admitted that sometimes his anger overcomes him, stating, "when something gets me mad, I jump out the anger real quick and let them know." (R. 109) He stated:

I wouldn't say I'm a nervous person. I'm always trying to think maybe I'm hyper or something. I'm not hyper, but I just got a lot of energy. It's hard for me to sit, sit down, you know, stay still. I don't like just sitting down just looking at walls, I like to be out.

(R. 109) He explained, "it's just sometimes the old mind - when that baby's wants to go off, it goes off. I have no control over it." (R. 110) DeBuhr acknowledged that medication sometimes helps control his manic episodes. (*Id*.)

He described his typical day as follows:

Well, my life hasn't been the rosiest since I have no work, no income. So, basically, I try to get out and get coffee. I'll [at]tend a few AA meetings a week. I'll maybe visit some friends if they're off work during the day or at night. I help take care of grandma, as long as, you know, she doesn't ask too much out of me. I have no vehicle or anything. Other than that, I really don't have much of a life.

(R. 109) He acknowledged that he is able to follow a schedule (R. 110), and that he had not had a manic episode for three-and-one-half months (R. 113).

He stated his back "goes out quite often," and five to ten times in the preceding ten years, it has gone out for a period of one to two weeks. (*Id*.) Because of these problems, he felt his lifting was restricted to 25 or 30 pounds. (R. 111) Also, because of his back pain he can have trouble walking until he gets "stretched out." (*Id*.) He no longer engages in bowling or golf, his favorite sports, because of the stress on his back. (*Id*.) He has no problem climbing stairs (*id*.), but he described some minor sleep difficulties. (R. 112) He also stated he had problems bending over and sitting. (R. 115)

In a Work Activity Report completed on May 12, 1997, the interviewer observed DeBuhr was "rather unkempt, seemed nervous & shakey [sic]. I think this young man has some definite emotional

problems." (R. 215)

In a Disability Report completed by DeBuhr on May 29, 1997, DeBuhr stated his disability was "Bi polar manic deppressant (sic)." (R. 160) He stated his disability "slows [him] way down physically & mentally." (*Id.*) He described the medications he was taking as Risperdal, Depakote, and Ativan, and said the Risperdal slows him down and the Depakote and Ativan cause drowsiness. (R. 173) He stated his condition had caused him to quit work. (R. 177)

On about the same date, DeBuhr completed a Function Report. (R. 181-185) He stated that due to his medication and illness, he has become very lazy and is unwilling to take care of his personal needs, such as grooming, or do household chores. (R. 182) He is unable to concentrate on reading, watching television, or listening to the radio. (R. 184) He stated he has quit or lost jobs because he was physically and mentally unable to perform up to expectations. (R. 185)

In a Work History Report completed at the same time as these reports, DeBuhr stated the following:

I'm a Bi Polar manic depressant [sic] whose [sic] on risperdal a Anti pshycotic [sic] drug, Depakote a mood alterating [sic] drug, Ativan for anxiety and [W]ellbutrin for depression. The doctor has had me off of work from Feb to Apr then let me go back to work only to find out I wasn't physically or mentally capable of doing jobs I normally could do. I was working for the Rudy Salem agency at the time and they said they didn't wan't [sic] to put me out on any more jobs because I couldn't handle them and that made them look bad and before I was one of there [sic] best workers in there [sic] eyes.

(R. 200) In a Pain Report completed by DeBuhr on May 29, 1997, he stated he has an aching, stabbing pain in his lower back at all times, and the pain bothers him until he takes a Motrin pill. (R. 202-03) The pain gets worse when he bends over. (R. 202)

On June 6, 1997, the manager of the Temporary Services Division of the Department of Disability Services completed a Work Performance Assessment. (R. 217-18) He observed that from July 1996 to December 1996, DeBuhr did well at the jobs where he was placed, but after January 1, 1997, his performance dropped off dramatically. (R. 217) After that date, DeBuhr was unable to comprehend instructions and could not adapt. (R. 218) DeBuhr's supervisors reported that he did not seem to be alert or able to pay attention to instructions. (*Id.*) The manager observed that "since being on his medicine, [DeBuhr] doesn't seem to have the energy, stamina, or mental alertness to be working." (*Id.*) The manager stated he would not place DeBuhr in a job for safety reasons. (*Id.*)

DeBuhr completed a "reconsideration" disability report on September 18, 1997. (R. 219-22) He stated he was suffering from mood swings and had difficulties sleeping, and his doctor had not released him to return to work. (R. 219)

DeBuhr's uncle, William Sievers, a pharmacist, testified he has known DeBuhr since birth. (R. 48-49) During the year preceding the hearing, DeBuhr had lived with his 90-year-old grandmother. (R. 49-50) For awhile, DeBuhr helped his grandmother with her meals, medication, shopping, and laundry, but at the time of the hearing, DeBuhr had "been sick and hasn't done as well." (R. 49) William asked DeBuhr to do nothing for his grandmother because he was undependable. (R. 51) William has witnessed several recent "episodes" where DeBuhr had gone "off the deep end," uncontrollably yelling and screaming. (R. 49-50) DeBuhr was "ranting and raving . . . about different things" to his grandmother. (R. 52) He

was unreliable in handing her funds. (R. 52-53) He was often angry and defensive. (R. 54) He has been looking like someone who has been awake for a long time. (R. 51)

William Sievers's twin brother, Bob Sievers, also testified at the hearing. (R. 59-82) Bob testified that because of DeBuhr's unpredictability, he has taken away all of DeBuhr's duties in caring for his grandmother. (R. 61) When asked by the ALJ if DeBuhr could handle a job as a filling station attendant, Bob replied, "You know, I have to be honest with you, Judge, I don't, I wouldn't want John right now, around anybody. Quite frankly, I just don't feel that he can, he just has the ability to do things well, without - he's unpredictable." (R. 73)

Christy Smith, DeBuhr's ex-wife, also testified at the hearing. (R. 82-100) She and DeBuhr had been married for about three years, but had divorced about sixteen months before the hearing. (R. 83) She testified that DeBuhr was not "normal," and was constantly depressed. (R. 84) DeBuhr was supposed to take medication for his manic depression, but often would not take it because he did not like the way it made him feel. (R. 93) She testified that when DeBuhr got into a heightened state of mania, he would become delusional. (R. 94) She did not believe he was capable of working at a full-time job. (*Id.*)

***2. DeBuhr's medical history***

DeBuhr's relevant medical records are summarized in Appendix A to this opinion. His relevant medical history begins in 1990, when he suffered a back strain and was given a temporary lifting restriction. (R. 279) Later, on July 31, 1990, he was involuntarily admitted to the Mental Health Institute in Cherokee, Iowa, for evaluation and treatment for drug addiction. (R. 522-25) He was noncompliant with treatment, so he was sent for an evaluation of a possible personality disorder or a psychiatric disturbance. During the evaluation, he was hostile, agitated, and in complete denial, and eventually was released as not treatable in a hospital setting. (R. 527) His "final diagnosis" was as follows:

Axis I: Alcohol Dependence 303.90

Polysubstance Dependence 304.90

Axis II: Personality Disorder, NOS

Axis III: Inclusion Cyst Right Maxillary Area

(*Id.*)

A few weeks later, on August 21, 1990, DeBuhr was hospitalized after ingesting some PCP, and then wandering around town "talking nonsense." (R. 328) The examining physician suspected malingering. (*Id.*) DeBuhr then was taken for a psychiatric evaluation, and was found to be "confused, agitated, paranoid and behaving inappropriately." (R. 303) Upon mental status examination, he was hostile and threatening, and appeared unkempt and disheveled. (R. 304) His affect was inappropriate, and his mood was elated and irritable. (*Id.*) His speech was coherent, but irrelevant and not goal directed. (*Id.*) His thought content revealed "echolalia, paranoia and bizarre, disorganized thinking." (*Id.*) He was oriented to person, but not to time or place. (*Id.*) His attention and concentration were grossly impaired, and his

judgment and insight were severely impaired. (*Id*.) His diagnosis was as follows:

Axis I: Psychotic disorder, not otherwise specified

Alcohol abuse

Polysubstance abuse

Axis II: Antisocial Personality Disorder

Axis III: No diagnosis

(*Id*.)

On September 6, 1990, Rodgers Wilson, M.D., a psychiatrist, diagnosed DeBuhr as having drug-induced psychotic behavior. (R. 301) By September 14, 1990, DeBuhr was exhibiting no assaultive or aggressive behavior (*id*.), and on September 17, 1990, Dr. Wilson noted DeBuhr was exhibiting no bizarre behaviors, and could carry on "very appropriate spontaneous conversation." (R. 298) However, Dr. Wilson also noted that psychological testing was consistent with "Bipolar Illness," so Axis I of his diagnosis was changed to "Bipolar Disorder, Depressed Type." (*Id*.) In progress notes dated September 19, 1990, Dr. Wilson noted that psychological testing revealed evidence of manic depressive episodes. (R. 300)

At the request of Dr. Wilson, on September 27, 1990, Jeanette Hatch, PhD. prepared a psychological assessment of DeBuhr. (R. 293-95) Dr. Hatch began by administering to DeBuhr the Minnesota Multiphasic Personality Inventory ("MMPI") test. She noted the MMPI profile appeared to be valid. (R. 294) Her assessment was as follows:

The clinical profile is notable for the elevation of scales that indicate a high energy level and potential to act out emotional distress. This pattern is seen with patients who demonstrate significant emotional disturbance and who lack insight into their illness. This profile is usually seen with patient[s] who are erratic and unpredictable in their behavior. They will demonstrate sudden excitement, confusion, disorientation, and hyperactivity. They will have difficulty focusing on an idea or topic and may be emotionally labile. They may engage in excessive daydreaming or fantasy and have difficulty relating to others.

Patients who obtain MMPI profiles similar to Mr. DeBuhr usually receive diagnoses of delusional disorder or bi-polar disorder. Because of the lack of insight into their illness which such patients demonstrate medication compliance may be difficult to obtain. Also, because of their high energy level and irritability it is not unusual for them to abuse alcohol, either just because it is something to do or because it provides some relaxation. Diagnosis and treatment may be more complex because of the associated chemical abuse problems.

(*Id*.) Dr. Hatch concluded that DeBuhr "is most probably mentally ill, with his diagnosis and treatment made more difficult by his previous use of drugs and alcohol, and his lack of insight into his behavior and emotional problems." (*Id*.)

On September 28, 1990, DeBuhr was discharged to his father's care on the following medications: Lithobid, Cogentin, Stelazine, Flexeril, Motrin, PeriColace and Metamucil. (R. 288) Dr. Wilson's diagnosis upon discharge was as follows:

Axis I: Bipolar disorder, depressed type 296.50

Polysubstance Dependence 304.90

Status post psychotic disorder, not otherwise specified (drug induced) 292.90

Axis II: No diagnosis

Axis III: Lumbar pain by history

(R. 289) As part of his aftercare plan, DeBuhr stated he planned to live off of SSI or disability because he "doesn't care to work or feel like working." (R. 290)

On October 13, 1990, DeBuhr was evaluated by another psychiatrist, Soa Yuc Lee, M.D. (R. 513-14) Dr. Lee diagnosed "poly-substance abuse dependence bi-polar disorder mixed type." (R. 514) DeBuhr continued to see Dr. Lee, and by March 2, 1991, DeBuhr informed Dr. Lee he had started a job that was "low stress" and was "back to his old self." (R. 520) DeBuhr did not show up for a scheduled follow-up appointment on May 2, 1991, and on October 29, 1992, Dr. Lee closed his file. (*Id*.)

The next reference in the administrative record to DeBuhr's psychiatric problems is in a report of a screening interview at Gordon Recovery Center on November 11, 1994, three-and-one-half years after DeBuhr's last visit with Dr. Lee. (R. 529-31) He was identified as possibly manic depressive, but was off his medication. His problem was identified as a "lack of knowledge of addiction & is in relapse." (R. 531) DeBuhr was admitted for drug and alcohol treatment, with a tentative discharge date of December 22, 1994. (R. 559-62, 613, 625-26) In an individualized treatment plan prepared November 22, 1994, the therapist at Gordon Recovery Center diagnosed DeBuhr as follows:

Axis I: 303.90 Alcohol dependent

304.30 Cannabis dependent

Axis II: deferred

Axis III: no medical complaint

Axis IV: 3-moderate, RTF, job, legal

Axis V: GAF:[(4)] Past Year 60. Current 55.

(R. 625) In a discharge summary prepared December 22, 1994, William Beyerkink, Ph.D. concluded that alcohol dependence was DeBuhr's primary problem. (*Id*.) DeBuhr was told to abstain from alcohol and other drugs, attend AA meetings, and participate in outpatient therapy. (*Id*.)

About two years later, on February 7, 1997, DeBuhr went to the Siouxland Community Health Center complaining of weight loss, increased stress, lung congestion, and back pain. (R. 481) He was started on Paxil for depression. (R. 482) On February 16, 1997, his wife called the Siouxland Community Health Center, stating that DeBuhr was becoming increasingly unstable, and was "talking crazy." (R. 480) His wife was advised to call the police, which she did. (*Id*.)

DeBuhr was picked up by the police and delivered to the Marion Health Center, where he was admitted by D.E. Maddela, M.D., a psychiatrist. (R. 227) Dr. Maddela took the following history:

Mrs. DeBuhr reports that her husband has been having an escalation in his behavior with agitation and anxiety over the past two weeks prior to this admission. She notes that approximately two weeks ago her husband was out drinking with friends and returned home very angry. The patient subsequently passed out on the sofa. When the patient awakened[,] his wife told him that he needed to return to AA or she would leave with the children. On 2/6/97 the patient was reported to have been using marijuana and complained to his wife that someone laced his marijuana with other medications. The patient became increasingly agitated again. On 2/7/97 Mrs. DeBuhr brought her husband to see Dana Peck at Siouxland Community Health for treatment of his anxiety. She prescribed Paxil and told Mrs. DeBuhr [he] needed a mood stabilizer because he appeared to have a bipolar disorder. It was noted that the patient told Dana that God was punishing him and this is the reason why he was suffering. The patient returned home and was relatively calm until 2/13/97[,] when the patient quit his warehouseman job and returned home very angry. The patient has been escalating with increasing psychomotor agitation which reached a peak on 2/15/97[,] when the patient was noted to have increasing psychomotor agitation, and illogical and pressured speech. Per Mrs. DeBuhr's report, over the past two weeks her husband has been only sleeping in two to four [hour] spurts. The patient has told his wife that he believes that people were poisoning him and that he is being punished by God. He also reported that his deceased Mom was talking to him and telling him what was good vs what was evil. The patient had increasing psychomotor agitation and was brought in by the Sioux City Police Department as requested by Mrs. DeBuhr for psychiatric evaluation at the Emergency Room.

(R. 229)

Dr. Maddela's "multi-axial assessment" was as follows:

Axis I: Bipolar disorder NOS, polysubstance abuse (marijuana, alcohol, cocaine, heroin)

Axis II: Deferred

Axis III: None.

Axis IV: Problems with primary support group (agitated behavior towards wife).

Axis V: Current global assessment of functioning equals 50, global assessment of functioning of previous year 65.[(5)]

(R. 231) DeBuhr was separately evaluated by J.D. Liewer, M.D., whose assessment was that DeBuhr had "paranoid thoughts, psychotic and delusional behavior." (R. 232)

Upon admission, DeBuhr immediately was started on Risperdal for treatment of paranoid delusions and auditory hallucinations, and was restrained "for safety." (R. 227, 231) On his second day at Marian Health Center, the dosage of Risperdal was increased, and he was started on Valproic, a mood stabilizer. (*Id*.) He remained nearly vegetative throughout his hospital stay, and demonstrated no further signs or symptoms of paranoid delusions. (R. 227)

DeBuhr was discharged on February 20, 1997. (*Id*.) Dr. Maddela developed the following plan for DeBuhr's ongoing treatment:

The patient had initial 48 hour court hold due to his manic/agitated behavior and increasing paranoid delusions. After the first day of admission, the patient was without psychotic signs and symptoms and his mood was vastly improved. The patient was cooperative with treatment recommendations and started the mood stabilizer and antipsychotics without side effect. In conferring with patient and his wife, it became apparent that the patient had a dual diagnosis of bipolar disorder NOS and polysubstance abuse. The patient and wife agreed that patient needed intense outpatient treatment/dual diagnosis of bipolar disorder and chemical dependency. The patient agrees to this and will have his initial intake interview at the Marian Behavioral Medicine Associates IOP program at 3 p.m. on the day of discharge, 2/20/97. Will contact the judicial referee, Les Gurdin and will fill out a physicians report with the above recommendations. The patient will attend the court hearing scheduled for tomorrow 2/21/97 at 3 p.m. The patient was without suicidal or homicidal ideations throughout this hospital stay. The patient has been without auditory visual hallucinations since the initiation of Risperdal. The patient will have initial outpatient medication management appointment at MBMA after completion of the IOP treatment program. I will continue to follow the patient and manage his psychotropic medications during the IOP program.

(R. 228)

Although DeBuhr's manic symptoms decreased after he began receiving his medications on a regular schedule (R. 243), his outpatient course was largely unsuccessful. He was discharged from the program on April 1, 1997, with the following summary of his response to treatment:

Client was reluctant all through treatment to develop coping skills around his manic stage, (no caffeine, take medication, Amicare nurse and identify responsibility in self care). Client was unable to follow through with treatment plan. Client was on and off medication. Did not follow doctor[']s recommendations. Would continue to drink caffeine, group confronted him daily. Client was released from Intensive Outpatient Program, he stated [he] was taking medication, questionable honesty level.

(R. 234) His GAF at the time of discharge was 55.[(6)] (*Id.*)

On April 2, 1997, the police took DeBuhr to Marian Health Center after he had a dispute with his wife. DeBuhr reported that he was to take Depakote, Risperdal, and Ativan, but he had stopped taking the Ativan because it make him sluggish and tired. R. 244) He also reported that he had relapsed in the preceding six months and had used alcohol and marijuana. (R. 245) He was diagnosed as "hypomanic." (*Id.*)

On April 15, 1997, Dr. Maddela saw DeBuhr, and assessed him as suffering from bipolar disorder (hypomanic). (R. 273) Dr. Maddela gave DeBuhr a prescription for Ativan, and strongly encouraged him to take the medication as scheduled. (*Id.*) Dr. Maddela again saw DeBuhr on May 13, 1997, and DeBuhr complained of difficulties with attention, concentration, and fatigue. (R. 272) He was assessed as suffering from bipolar disorder (depressed). (R. 271) Dr. Maddela prescribed Wellbutrin Slow Release[(7)] to treat the depression. Dr. Maddela saw DeBuhr again on May 20, 1997, and DeBuhr said he was reluctant to take Ativan because "he enjoys his manic episodes." (R. 401) On June 10 and July 9, 1997, Dr. Maddela saw DeBuhr and attempted to adjust the dosages of DeBuhr's medication. (R. 267-70)

On July 23, 1997, Carole Kazmierski, Ph.D. completed a "Psychiatric Review Technique" form on DeBuhr.[(8)] (R. 248-56) Dr. Kazmierski found no evidence DeBuhr had any organic mental disorder; schizophrenic, paranoid, or other psychotic disorder; mental retardation or autism; anxiety related disorder; somatoform disorder, or personality disorder. (R. 248) DeBuhr did have an affective mood disorder, evidenced by "disturbance of mood, accompanied by a full or partial manic or depressive syndrome," as evidenced by "bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes)." (R. 248, 251) He also had a substance addiction disorder. (R. 248, 254)
Dr. Kazmierski found that DeBuhr was moderately restricted in his activities of daily living, in maintaining social functioning, and in concentration and persistence or pace, which resulted in a failure to complete tasks in a timely manner. (R. 255) Once or twice in the past, he had experienced episodes of deterioration or decompensation in work or work-like settings. (*Id.*)

Also on July 23, 1997, Dr. Kazmierski completed a "Mental Residual Functional Capacity Assessment" form on DeBuhr.[(9)] (R. 257-60) According to Dr. Kazmierski, DeBuhr was not limited significantly in the ability to remember locations and work-like procedures, or to understand and remember very short and simple instructions. (R. 257) He was moderately limited in the ability to understand and remember detailed instructions, but was not limited significantly in his ability to carry out very short and simple instructions, perform activities within a schedule, maintain regular attendance, be punctual within customary tolerances, sustain an ordinary routine without special supervision, work in coordination with or proximity to others without being distracted by them, or make simple work-related decisions. (*Id.*) He was moderately limited in his ability to carry out detailed instructions and to maintain attention and concentration for extended periods of time, to complete a normal work day and work week without interruptions from psychologically-based symptoms, and to perform at a consistent pace without an

unreasonable number and length of rest periods. (R. 257-58) DeBuhr also was moderately limited in his ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes, and to respond appropriately to changes in the work setting, but otherwise was not limited significantly in the areas of social interaction or adaptation. (R. 258)

In her notes accompanying the assessment, Dr. Kazmierski included the following additional comments:

With continued treatment, avoidance of drug & alcohol abuse & medical compliance, claimant's condition should stabilize & it is reasonable to expect that he would be capable of SGA (*i.e.*, Substantial Gainful Activities) prior to 2/98.

(R. 259)

On August 1, 1997, James Loutzenhiser, M.D. completed forms in which he stated he agreed with all of Dr. Kazmierski's conclusions. (R. 263-66)

DeBuhr saw Dr. Maddela again on August 20 (R. 265-66), September 30 (R. 414-15), and November 12 (R. 412-13), 1997, and January 14 (R. 410-11), February 25 (R. 408-09), May 6 (R. 406-07), and July 15 (R. 404-05), 1998. DeBuhr exhibited no significant change in his condition until January 14, 1998, when he reported that although he continued to be depressed, he had adequate energy levels and was receiving approximately eight hours of restful sleep nightly. (R. 410) On February 25, 1998, he reported "he continues to do fine except for feelings of loneliness at times," and Dr. Maddela changed his diagnosis to "Bipolar I Disorder (depressed, in partial remission)." (R. 408) Dr. Maddela encouraged DeBuhr to consider volunteer activities to decrease his sense of isolation. (*Id*.) On July 15, 1998, Dr. Maddela noted sustained improvement in DeBuhr's mood (R. 405), although his affect was "restricted" and his insight was only "fair." (R. 404) He again changed his diagnosis, to "Bipolar I Disorder (in remission)." (*Id*.) Dr. Maddela scheduled a follow-up medication check for fourteen weeks (R. 405), but the administrative record does not contain mention of any further treatment of DeBuhr by Dr. Maddela.

About three months later, after a bar fight on October 30, 1998, DeBuhr was involuntarily admitted into the Mental Health Institute in Cherokee, Iowa. (R. 423-26) Upon admission, DeBuhr admitted he stopped taking his medication "a couple of months ago" because he was unable to perform sexually. (R. 423) He also admitted he had started drinking again, and that he still smoked marijuana "from time to time." (R. 423-24) On the night of his admission, he presented "as a lethargic but surly and angry young man." (*Id*.) On November 2, 1998, DeBuhr's treating doctor, M. Christine Massie, D.O., made the following diagnosis:

Axis I: Bipolar Disorder, Manic Phase 296.04

Alcohol Dependence, by History 303.90

Mixed Substance Dependence, by History

Axis II: No Diagnosis V71.09

Axis III: Physically Healthy V70.0

Axis IV: Psychosocial Stressors: None

Axis V: GAF = 20 (admission); today 34[(10)]

(R. 425) Dr. Massie's treatment plan was for DeBuhr to start back on his medication. (R. 426) At the time of his discharge, on November 3, 1998, DeBuhr was "in good spirits and had plans for the future." (R. 422) However, during an outpatient visit on the day after his release, his speech was rapid and pressured, and he was "extremely irritable." (R. 417)

In a "Discharge Diagnosis" prepared by Chule H. Auh, M.D. on November 10, 1998, Dr. Auh made the following assessment:

Axis I: Bipolar I Disorder, Manic with Psychotic Features 296.04

Alcohol Dependence, by History 303.90

Polysubstance Dependence, by History

Axis II: No Diagnosis V71.09

Axis III: Without Acute Illness V70.0

Axis IV: Marked Difficulties in Interpersonal Relationship

Non-compliance with Medication

Axis V: GAF = 65 (discharge)[(11)]

(R. 419)

During an outpatient visit to Marian Health Center on November 12, 1998, DeBuhr complained of sleep irritability and demonstrated pressured speech. (R. 416) DeBuhr refused to consider medication for his condition, so he was referred to Siouxland Mental Health Clinic. (*Id*.) He had his first individual session

at Siouxland Mental Health with Jennifer K. Burrows, MSW, LISW, on December 1, 1998. (R. 493) DeBuhr reported he was sleeping more and taking his medication. (*Id.*) DeBuhr saw Burrows again on December 8 and 15, 1998, and appeared to be more calm. (R. 491-92)

On December 21, 1998, DeBuhr saw Philip J. Muller, M.D., a psychiatrist at Siouxland Mental Health. (R. 489-90) DeBuhr's mood was good, and his mental status appeared to be essentially normal. (R. 489) Dr. Muller noted DeBuhr had "some slight pressured speech, slightly elevated affect, but in general he's been sleeping reasonably well, with the exception of occasionally only 3 to 4 hours of sleep." (R. 490) Dr. Muller's diagnostic impression was "Bipolar Mood Disorder I." (*Id.*)

Burrows saw DeBuhr on December 22, 1998 (R. 488), and January 5 (R. 510) and January 12 (R. 511), 1999. During these sessions, DeBuhr admitted to "fudging" with his medication (R. 488), but generally appeared to be calm. DeBuhr failed to show for a January 19, 1999, appointment. (R. 512)

The administrative record contains a "Psychiatric Review Technique" form dated July 28, 2000 (R. 659-67), and a "Mental Residual Functional Capacity Assessment" form dated August 10, 2000 (R. 656-68), both completed after the ALJ issued his decision on April 22, 1999. The forms were completed by Dr. Philip J. Muller, who has treated DeBuhr since November 12, 1998. (*See* Doc. No. 9, p. 18) Dr. Muller found DeBuhr met the listing for an affective disorder under listing 12.04. (R. 659) He found no evidence that DeBuhr had any organic mental disorder; schizophrenic, paranoid, or other psychotic disorder; mental retardation or autism; anxiety related disorder; somatoform disorder; personality disorder; or substance addiction disorder. (*Id.*) According to the reviewer, DeBuhr did have an affective mood disorder, evidenced by a variety of depressive and manic symptoms and by a history of bipolar syndrome. (R. 662) Dr. Muller found DeBuhr was not restricted in his activities of daily living, but was extremely limited in maintaining social functioning, and frequently was limited in concentration and persistence or pace, which resulted in a failure to complete tasks in a timely manner. (R. 666) He also found DeBuhr frequently experienced episodes of deterioration or decompensation in work or work-like settings. (*Id.*)

According to the "Mental Residual Functional Capacity Assessment" form completed by Dr. Muller, DeBuhr was markedly limited in his ability to remember locations and work-like procedures, and moderately limited in his ability to understand and remember both very short and simple instructions and detailed instructions. (R. 656) He also was moderately limited in his ability to carry out very short and simple instructions, sustain an ordinary routine without special supervision, and make simple work-related decisions. (*Id.*) He was markedly limited in his ability to carry out detailed instructions, maintain attention and concentration for extended periods of time, work in coordination with or in proximity to others without being distracted by them, complete a normal work day and work week without interruptions from psychologically-based symptoms, and perform at a consistent pace without an unreasonable number and length of rest periods. (R. 656-57) According to Dr. Muller, DeBuhr also was markedly limited in most areas of social interaction and adaptation. (R. 657)

***3. Vocational expert's testimony***

VE Sandra Trudeau testified at the February 10, 1999, hearing. (R.116-19) The ALJ asked the VE the following question:

Let's assume for instance, that we have someone of Mr. DeBuhr's age, education and past work history,

both exertional and skill level, and with the transferable skills, which you have indicated on Exhibit 6E, and with the following limitations then. That he could lift 20 pounds on occasion, 10 pounds on a frequent basis. Then with a sit-stand option, he could work an eight hour day, with normal breaks. That he should, that he would be able to occasionally bend, stoop and kneel.

(R. 117) The VE testified that the hypothetical claimant would not be able to perform any of DeBuhr's past relevant work, but could perform certain unskilled occupations, such as cashier, assembler, and hand packager. (R. 118)

The ALJ then asked the VE a second hypothetical question, adding a restriction that the hypothetical claimant should have minimum contact with his supervisors and the public. (*Id*.) The VE testified that only the cashier job would be eliminated. (R. 119) When asked about the effect on employment of hospitalizations for manic depressive circumstances once or twice a year, the VE testified as follows:

[G]enerally when you work for someone, you have at least one week off during a year. If that would fall on his vacation time, it probably wouldn't hurt, but if it would fall during the work time that they expected him to be there and it would happen two times in there, I would think that he would not be able to sustain employment.

(*Id*.)

***4. The ALJ's conclusion***

The ALJ found DeBuhr had not engaged in substantial gainful activity since February 13, 1997, the date of his alleged disability. (R. 17) The ALJ concluded DeBuhr suffered from bipolar mood disorder and back problems, impairments that presented "severe" limitations under the Social Security Administration's Regulations. (*Id*.) DeBuhr also had a history of polysubstance abuse, currently in remission. (*Id*.) The ALJ found DeBuhr's impairments did not meet or equal the "listings." (R. 18) The ALJ also found DeBuhr, because of his medically determinable impairments, is not longer able to perform his past relevant work. (R. 24) However, the ALJ found that although DeBuhr could not perform the "full range" of sedentary and light work (because of his psychological symptoms), he could perform the sedentary and light occupations described by the VE. (R. 26)

In reaching his decision, the ALJ discounted DeBuhr's testimony that he was totally disabled after summarizing the medical and psychiatric evidence (R. 21-22), concluding as follows:

Because it is reasonable to conclude from the above reports that proper compliance with medication, particularly Depakote, would diminish the Claimant's psychological symptoms, and since he has not established good cause for his non-compliance, his testimony regarding the intensity, frequency, and duration of his symptoms is not credible.

(R. 22) The ALJ also found the allegations of total disability by DeBuhr's uncles and former wife were not entitled to significant weight. (R. 23-24)

Accordingly, the ALJ found DeBuhr was not under a disability as defined by the Social Security Act at any time through the date of the decision. (R. 27)

### *III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD*

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering . . . his age, education and work experience, engage in any other kind of substantial gainful work which exists in [significant numbers in] the national economy . . . either in the region in which such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *see Kelley*, 133 F.3d at 587-88 (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner must determine whether the claimant is currently engaged in substantial gainful activity. Second, he looks to see whether the claimant labors under a severe impairment; *i.e.*, "one that significantly limits the claimant's physical or mental ability to perform basic work activities." *Kelley*, 133 F.3d at 587-88. Third, if the claimant does have such an impairment, then the Commissioner must decide whether this impairment meets or equals one of the presumptively disabling impairments listed in the regulations. If the impairment does qualify as a presumptively disabling one, then the claimant is considered disabled, regardless of age, education, or work experience. Fourth, the Commissioner must examine whether the claimant retains the residual functional capacity to perform past relevant work.

Finally, if the claimant demonstrates the inability to perform past relevant work, then the burden shifts to the Commissioner to prove there are other jobs in the national economy that the claimant can perform, given the claimant's impairments and vocational factors such as age, education and work experience. *Id.*; *Hunt v. Heckler*, 748 F.2d 478, 479-80 (8th Cir. 1984) ("[O]nce the claimant has shown a disability that prevents him from returning to his previous line of work, the burden shifts to the ALJ to show that there is other work in the national economy that he could perform.") (citing *Baugus v. Secretary of Health & Human Serv.*, 717 F.2d 443, 445-46 (8th Cir. 1983); *Nettles v. Schweiker*, 714 F.2d 833, 835-36 (8th Cir. 1983); *O'Leary v. Schweiker*, 710 F.2d 1334, 1337 (8th Cir. 1983)).

Step five requires that the Commissioner bear the burden on two particular matters:

In our circuit it is well settled law that once a claimant demonstrates that he or he is unable to do past relevant work, the burden of proof shifts to the Commissioner to prove, first that the claimant retains the residual functional capacity to do other kinds of work, and, second that other work exists in substantial numbers in the national economy that the claimant is able to do. *McCoy v. Schweiker*, 683 F.2d 1138, 1146-47 (8th Cir. 1982) (*en banc*); *O'Leary v. Schweiker*, 710 F.2d 1334, 1338 (8th Cir. 1983).

*Nevland v. Apfel*, 204 F.3d 853, 857 (8th Cir. 2000) (emphasis added) *accord Weiler*, 179 F.3d at 1110 (analyzing the fifth-step determination in terms of (1) whether there was sufficient medical evidence to support the ALJ's residual functional capacity determination and (2) whether there was sufficient evidence to support the ALJ's conclusion that there were a significant number of jobs in the economy that the claimant could perform with that residual functional capacity); *Fenton v. Apfel*, 149 F.3d 907, 910 (8th Cir. 1998) (describing "the Secretary's two-fold burden" at step five to be, first, to prove the claimant has the residual functional capacity to do other kinds of work, and second, to demonstrate that jobs are available in the national economy that are realistically suited to the claimant's qualifications and capabilities).

Governing precedent in the Eighth Circuit requires this court to affirm the ALJ's findings if they are supported by substantial evidence in the record as a whole. *Weiler v. Apfel*, 179 F.3d 1107, 1109 (8th Cir. 1999) (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *Kelley v. Callahan*, 133 F.3d 583, 587 (8th Cir. 1998) (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive. . . ."). Under this standard, substantial evidence means something "less than a preponderance" of the evidence, *Kelley*, 133 F.3d at 587, but "more than a mere scintilla," *Richardson v. Perales*, 402 U.S. 389, 401, 91 S. Ct. 1420, 1427, 28 L. Ed. 2d 842 (1971); *accord Ellison v. Sullivan*, 921 F.2d 816, 818 (8th Cir. 1990). Substantial evidence is "relevant evidence which a reasonable mind would accept as adequate to support the [ALJ's] conclusion." *Weiler*, 179 F.3d at 1109 (again citing *Pierce*, 173 F.3d at 706); *Perales*, 402 U.S. at 401, 91 S. Ct. at 1427; *accord Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993); *Ellison*, 91 F.2d at 818.

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account "'whatever in the record fairly detracts from'" the weight of the ALJ's decision. *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *accord Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213). Thus, the review must be "more than an examination of the record for the existence of substantial evidence in support of the Commissioner's decision"; it must "also take into account whatever in the record fairly detracts from the decision." *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Gavin v. Heckler*, 811 F.2d 1195, 1199 (8th Cir. 1987)). The court, however, does "not reweigh the evidence or review the factual record *de novo*." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (quoting *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992) (citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *see Hall v. Chater*, 109 F.3d 1255, 1258 (8th Cir. 1997) (citing *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996)). This is true even in cases where the court "might have weighed the evidence differently," *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)), because the court may not reverse "the Commissioner's decision merely because of the existence of substantial evidence supporting a different outcome." *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997).

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.,* 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen,* 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.*, 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.,* 823 F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala*, 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan,* 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler,* 739 F.2d 1320, 1322 (8th Cir. 1984)). Under *Polaski:*

The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:

1) the claimant's daily activities;

2) the duration, frequency and intensity of the pain;

3) precipitating and aggravating factors;

4) dosage, effectiveness and side effects of medication;

5) functional restrictions.

*Polaski,* 739 F.2d at 1322.

***IV. ANALYSIS***

As noted previously, DeBuhr argues the ALJ failed to give appropriate weight to the opinions of his primary treating physicians. In particular, DeBuhr argues the Appeals Council failed to consider the Psychiatric Review Technique and Mental Residual Functional Capacity Assessment forms completed by Dr. Muller after the ALJ issued his opinion. (*See* Doc. No. 9, p. 18) In the reports, Dr. Muller found DeBuhr to be limited in numerous areas that would restrict him from virtually any type of employment.

In *Prosch v. Apfel*, 201 F.3d 1010 (8th Cir. 2000), the Eighth Circuit Court of Appeals discussed the weight to be given to the opinions of treating physicians:

The opinion of a treating physician is accorded special deference under the social security regulations. The regulations provide that a treating physician's opinion regarding an applicant's impairment will be granted "controlling weight," provided the opinion is "well-supported by medically acceptable clinical

and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in [the] record." 20 C.F.R. § 404.1527(d)(2). Consistent with the regulations, we have stated that a treating physician's opinion is "normally entitled to great weight," *Rankin v. Apfel*, 195 F.3d 427, 430 (8th Cir. 1999), but we have also cautioned that such an opinion "do[es] not automatically control, since the record must be evaluated as a whole." *Bentley v. Shalala*, 52 F.3d 784, 785-86 (8th Cir. 1995). Accordingly, we have upheld an ALJ's decision to discount or even disregard the opinion of a treating physician where other medical assessments "are supported by better or more thorough medical evidence," *Rogers v. Chater*, 118 F.3d 600, 602 (8th Cir. 1997), or where a treating physician renders inconsistent opinions that undermine the credibility of such opinions, *see Cruze v. Chater*, 85 F.3d 1320, 1324-25 (8th Cir. 1996).

Whether the ALJ grants a treating physician's opinion substantial or little weight, the regulations provide that the ALJ must "always give good reasons" for the particular weight given to a treating physician's evaluation. 20 C.F.R. § 404.1527(d)(2); *see also* SSR 96-2p.

*Prosch*, 201 F.3d at 1012-13. *Accord Wiekamp v. Apfel*, 116 F. Supp. 2d 1056, 1063-64 (N.D. Iowa 2000) (Bennett, C.J.).

In this case, the ALJ did not have the benefit of Dr. Muller's comprehensive review of all of DeBuhr's medical records, or Dr. Muller's reports prepared on Social Security forms. The Appeals Council noted it had considered Dr. Muller's reports, but offered no analysis other than the conclusion that the additional evidence did not provide a basis for changing the ALJ's decision. (R. 5) Under these circumstances, as the Eighth Circuit has explained:

When the Appeals Council has considered new and material evidence and declined review, we must decide whether the ALJ's decision is supported by substantial evidence in the whole record, including the new evidence.

*Kitts v. Apfel*, 204 F.2d 785, 786 (8th Cir. 2000) (citing *Mackey v. Shalala*, 47 F.3d 951, 953 (8th Cir. 1995)); *accord Gartman v. Apfel*, 220 F.3d 918, 922 (8th Cir. 2000) (citing *Kitts, Mackey*). While noting this is a rather "peculiar task for a reviewing court," our Circuit nevertheless has elected to include "such evidence in the substantial evidence equation." *Mackey v. Shalala*, 47 F.3d 951, 953 (8th Cir. 1995).

Thus, this court must determine, considering the entirety of the record, whether the ALJ's determination that DeBuhr was not disabled is supported by substantial evidence. The court finds it is not. The record as a whole paints the picture of a man with a serious bipolar disorder who is permanently impaired in his ability to engage in substantial gainful activity. While it appears DeBuhr would be able to work if he were vigilant in complying with his medication regimen, Dr. Muller noted DeBuhr's noncompliance is, itself, a symptom of the bipolar disorder. (R. 655) Thus, it is unlikely DeBuhr will ever be stable for a long enough term to allow him to maintain permanent employment. Evidence in the record repeatedly refers to DeBuhr's failure to comprehend the nature of his illness and the necessity for strict compliance with his treatment protocol in order to maintain his ability to avoid manic and depressive episodes.

Accordingly, the court finds substantial evidence exists in the record to determine that DeBuhr is disabled and entitled to benefits. Having so found, the court need not address DeBuhr's second assignment of error, but nevertheless finds the hypothetical question posed by the ALJ failed to consider adequately the scope and consequences of DeBuhr's bipolar disorder.

Finally, the court notes that Dr. Muller, DeBuhr's treating physician, recommends DeBuhr be provided with assistance in managing his benefits "because of his history of mania." The court concurs with this recommendation.

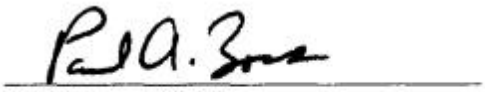
## *V. CONCLUSION*

Having found DeBuhr is entitled to benefits, the court may affirm, modify or reverse the Commissioner's decision with or without remand to the Commissioner for rehearing. 42 U.S.C. § 405(g). In this case, where the record itself "convincingly establishes disability and further hearings would merely delay receipt of benefits, an immediate order granting benefits without remand is appropriate." *Cline*, 939 F.2d at 569 (citing *Jefferey v. Secretary of H.H.S.*, 849 F.2d 1129, 1133 (8th Cir. 1988); *Beeler v. Bowen*, 833 F.2d 124, 127-28 (8th Cir. 1987)); *accord Thomas v. Apfel*, 22 F. Supp. 2d 996, 999 (S.D. Iowa 1998) (where claimant is unable to do any work in the national economy, remand to take additional evidence would only delay receipt of benefits to which claimant is entitled, warranting reversal with award of benefits). Consequently, it is recommended that the court reverse the ALJ's decision and remand this case to the Commissioner for an award of benefits in the appropriate amount.

**IT IS RECOMMENDED**, unless any party files objections[(12)] to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that judgment be entered in favor of DeBuhr[(13)] and against the defendant, and that this case be **reversed and remanded** to the Commissioner for the calculation and award of DI and SSI benefits.

**IT IS SO ORDERED.**

**DATED** this 18th day of December, 2001.



PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT

1. On November 14, 2001, Jo Anne B. Barnhart was sworn in as Commissioner of Social Security, and she is hereby substituted as defendant in this action. *See* Fed. R. Civ. P. 25(d)(1); *cf.* Fed. R. App. P. 43(c)(2).

2. According to a report DeBuhr filed with the Social Security Administration, he actually received a "Chapter 9 discharge" after one year because of an alcohol rehabilitation failure. (R. 179)

3. DeBuhr testified he had no insurance and was unable to pay for a prescription, so his doctor was giving him samples of the medication. (R. 105-06)

4. "GAF is an abbreviation for "Global Assessment of Functioning." *See* App. A, note 3.

5. *See* Appendix A, notes 3, 6.

6. *See* Appendix A, note 3.

7. Dr. Maddela noted this was the least likely of the anti-depressants to lead to a "manic overshoot." (R. 272)

8. On October 21, 1997, Dee E. Wright, Ph.D. noted on the form that she agreed with the conclusions reached by Dr. Kazmierski. (R. 248)

9. On October 21, 1997, Dr. Wright noted on the form that she agreed with Dr. Kazmierski's conclusions. (R. 259)

10. *See* Appendix A, note 9.

11. *See* Appendix A, note 6.

12. Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).

13. If final judgment is entered for the plaintiff, the plaintiff's counsel must comply with the requirements of Local Rule 54.2(b) in connection with any application for attorney fees.